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Child Information Form

Today's Date: ____________________ Completed by: □ Mother □ Father □ Other
Child's Name: __________________________________ Date of Birth: ___________
Address: ____
Home Phone: __________________________

Parent's Name: _____________________________________
Address: ____
Home Phone: ____________________Work Phone: _______________________
Cell Phone: _______________________ Email: _____________________________
Years of Education: _______________ Occupation: __________________________

Parent's Name: ______________________________________
Address: ____
Home Phone: _______________________Work Phone: ____________________
Cell Phone: _________________________Email: _________________________
Years of Education: __________________Occupation: _______________________

Parents' Relationship Status:
□ Married □ Never Married □ Separated □ Divorced □ Partnered □ Widowed
If divorced, who is the managing conservator? ______________________________

Siblings (including step-siblings and half-siblings):
Name Age Gender
1.
2.
3.
4.

Others in the home (grandparents, cousins, family friends):
Name Age Gender
1.
2.
3.
4.

Significant Life Events in the Last Two Years

□ Death of a loved one
□ Move/School change
□ Financial problems for the family
□ Parental remarriage/ new step-siblings
□ Birth of a new sibling
□ Trauma (violence, natural disaster, car accident, etc)
□ Other ____
□ Divorce/Separation
□ Medical Problems for any family member
□ Legal problems for the family (assault, DUI, etc)

Child's Strengths or Abilities

□ Academics/grades □ Sports □ Creative (art or music, etc)
□ Group involvement (clubs, organizations)
□ Religious involvement
□ Sense of humor
□ Care for others
Other: ____
____

Current Concerns about Your Child

□ Behavior at home/school □ Mood □ Eating □ Sleeping
□ Suicidal thoughts □ Academic performance/grades
□ Anger/Irritability □ Difficulty paying attention
□ Peer relationships □ Health □ Drugs/alcohol □ Sexual behavior
□ Frequent worries/shyness □ Sensitive to touch, sound, light, motion
Comments: ____
____

Is there a history of any previous treatment or any evaluations? □ Yes □ No If so, when and by whom?
□ Educational evaluation: ______________________________________
□ Psychological evaluation: _____________________________________
□ Outpatient therapy: ____
□ Hospitalization(s): ____
Does your child take medication? □ Yes □ No
If so, please list medication(s) and dosage(s): ___________________________
____
Who is the prescribing physician? ____________________________________

Child's Medical History

□ Medical problems during pregnancy
□ Maternal drug or alcohol use during pregnancy
□ Premature birth (if so, weight at birth: _____________ gestational age: __________)
□ Complications during birth (ex. Emergency C-section, low oxygen, etc)
□ Stayed in neonatal intensive care (if so, how long? ______________________)
□ Health problems as a newborn or toddler
□ Frequent ear infections
□ Asthma or allergies
□ Head injuries/concussions/seizures/fevers over 104 degrees
□ Serious accidents/hospitalizations
□ Surgeries
□ Problems with eating or sleeping

Child's Physician____
Comments: ____
____

Child's Developmental History

Problems with...?
□ Sitting up □ Walking □ Talking □ Toileting □ Bedwetting
□ Writing letters or using scissors □ Reading or letter identification
□ Physical coordination (running, jumping, climbing)
□ Responding to discipline or behavior management
□ Anger/temper tantrums □ Fears □ Sexual play
Other: ____

Child's Academic History

Current School: ____ School location: ____________________________ Grade: ___________
Teacher(s):____
Has your child...?
□ Repeated a grade □ Skipped school □ Been suspended □ Been expelled
□ Stopped doing homework □ Been bullied by others □ Been aggressive at school
□ Received an IEP or 504 plan
□ Received any special services (OT, PT, Reading, Speech, Self-Contained, etc)

Child's Social Relationships

Does your child have a friend or friends outside the family? □ Yes □ No
Do you know them? □ Yes □ No
Do his/her friends tend to be: □ older □ younger □ about the same age as your child
How well does your child get along with others?
____
____

Family History

Has anyone in your family struggled with (treated or untreated):

□ Depression or Bipolar Disorder
□ Anxiety
□ Learning problems (reading, math, spelling)
□ Attention problems
□ Excessive alcohol or drug use
□ Sexual abuse
□ Physical abuse
□ Suicide attempts or completed suicide

Do you have any other concerns about your child?

____

____

____

How did you hear about me and my services?

____

____

____

What do you hope to accomplish by working with me?

____

____

____